

Money Follows the Person Rebalancing Demonstration Proposal

State of Connecticut



**Submitted by:
Connecticut Department of Social Services**

November 1, 2006

CFDA 93.779

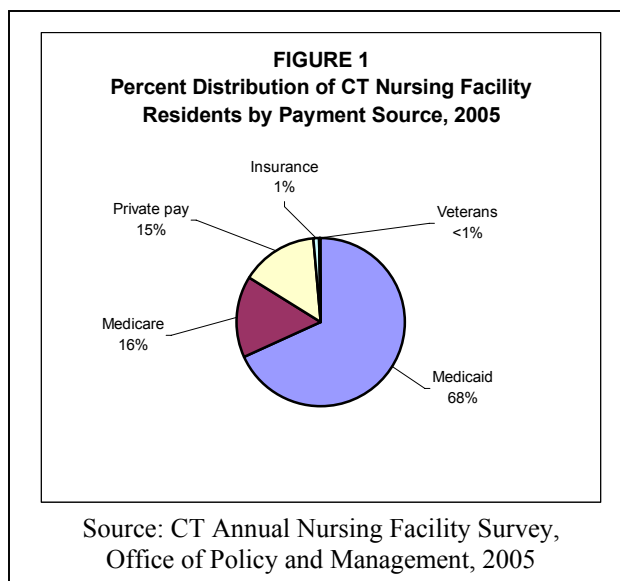
Part 1: Systems Assessment and ap Analysis (20 pages)

1. *A description of the current LTC support systems that provide institutional and home and community-based services, including any major legislative initiatives.*

The State of Connecticut has been reshaping its long term care services and supports to meet the needs of its residents. Long-term care is seen broadly as services and supports provided in a variety of settings over an extended period of time. This section will describe the current system in terms of the following categories: Institutional care settings, Medicaid Home and Community Based Services Options and Community Level Supports.

Institutional Care Settings

Connecticut's institutional care settings include skilled nursing facilities (SNF), Intermediate Care Facilities for the Mentally Retarded (ICF/MR) and Chronic Disease Hospitals. Institutions for Mental Disease (IMD) also provide institutional care for individuals with mental illness.



Home and Community Based Services:

The expansion of community based supports have allowed increasing numbers of individuals to remain in their homes and avoid or delay moving to an institutional setting. These supports encompass a wide range of formal and informal services and independence sustaining aids.

Medicaid State Plan Options: Connecticut's Medicaid State Plan provides a myriad of HCBS services. Relevant to MFP are the home health services, including skilled nursing, physical therapy, speech therapy, homemaker/home health aide service, occupational therapy and medical

social services; durable medical equipment; a rehabilitation option for individuals with mental illness. Each of these will be described in detail later in the proposal.

Medicaid Waivers: Connecticut's largest system providing support to persons with disabilities and older persons as an alternative to institutional care is the waiver system. DSS serves as the lead Medicaid agency in the state. Connecticut offers six Medicaid Home and Community-Based Waivers, operated by the Department of Social Services (DSS). Connecticut's five 1915(c) waivers include the CT Home Care Program for Elders (CHCPE, Elder Waiver), the Personal Care Assistance (PCA) Waiver, the Acquired Brain Injury (ABI) Waiver, the DMR Individual and Family Support (IFS) Waiver and the DMR Comprehensive Waiver, as well as the Katie Beckett Model Waiver.

State Long-Term Care Programs: There are a wide range of other long-term care services that support individuals with disabilities and chronic health conditions funded or operated by State agencies in addition to those mentioned above. A description of these programs was compiled by the Office of Policy and Management (OPM), as listed in Appendix 5.

Community Housing Options

A range of housing options with long-term care supports is available in Connecticut, affording individuals who have long-term care needs the ability to avoid entering into an institution.

Housing Type	Facilities	Units	Residents	Age
Congregate Housing 2005	23	Varied	951	62 and older
Assisted Living 2006	109	6,900	Varied	Adults and elders
Residential Care Homes 2006	102	2,826	2,593	Adults and elders
CCRCs 2006	17	3,200	Varied	Elders
Nursing Facilities 2006	246	29,540 Beds	27,575	All ages

Congregate Housing provides frail elders with private living arrangements, moderate supportive services as well as common areas for dining, socialization and other activities.

Assisted Living Services/Managed Residential Communities offer an attractive residential alternative to seniors age 55 and older who do not require the intensive care provided in nursing facilities. In Connecticut, assisted living service agencies (ALSAs) are licensed to provide assisted living services in managed residential communities (MRC). Collaborative interagency efforts have resulted in expanding the assisted living services to lower-income individuals. In the “Assisted Living Demonstration Project”, 4 subsidized pilots were approved by the General Assembly in 2001. Medicaid coverage for assisted living services has also been extended to State-funded congregate housing, federally financed HUD complexes and a pilot for up to 75 people who reside in private pay assisted living facilities.

Residential Care Homes (RCH) provide a room, meals and supervision for individuals whose limitations prevent them from living alone and do not require nursing services.

DMR group homes are licensed facilities which include group homes, community training homes and community living arrangements for individuals whose limitations require assistance.

Continuing Care Retirement Communities (CCRC) offer lifetime living accommodations and a wide variety of services, including a specified package of long-term health and nursing services for older adults. People usually enter these living arrangements while living independently, but are able to receive services at any level of care required as they age.

Supportive Housing in Connecticut is a Supportive Housing Demonstration Program that provides affordable, independent housing with a social service component for tenants who require such services. Supportive housing tenants choose to live in the housing, hold the lease and cannot be evicted for non-compliance with social services treatment plans. Approximately 70% of the units are reserved for individuals who were formerly homeless or at risk for

becoming homeless; 50 % are reserved for people with HIV/AIDS, mental illness, or chronic substance abuse.

Residential Settings for Individuals with Psychiatric Disabilities: The Department of Mental Health and Addiction Services (DMHAS) funds several types of 24-hour, seven day/week residential settings for individuals 18 and older, including group homes, supervised housing, long-term treatment, long term care and transitional care halfway houses.

Community Level Supports

Municipal, non-profit, private sector and volunteer services: In addition to the State programs, a wide array of statewide, regional and local long-term care supports and services exist throughout Connecticut. Government agencies, non-profit and for-profit organizations, as well as volunteer groups administer these. This includes 5 regional Independent Living Centers, 5 Area Agencies on Aging, statewide and local mental health councils, advisory councils for persons with disabilities, as well as the Corporation for Independent Living, a non-profit partner focused on new housing initiatives for elders and persons with disabilities.

Recent Legislative Initiatives:

In the 2005 and 2006 Sessions of the Connecticut General Assembly, tremendous advances were made in long-term care legislation. A listing of the major components follows, with the full description of each component available in the Appendix.

- Expansion of eligibility for a number of state Medicaid programs to persons beyond age 65 to eliminate age bias in programs. (PCA, ABI Waivers, Medicaid Buy-In program).
- Expansion of eligibility for all the ABI, PCA and the DMR Comprehensive Waivers to include working individuals with disabilities covered under the Medicaid Buy-In program.
- Expansion of the state-funded Personal Care Assistance Pilot.

Connecticut's MFP Demonstration

- Expansion of the 1915b Managed Care Waiver to allow the Connecticut Behavioral Health Partnership (CT BHP) to develop community-based alternatives to institutional care.
 - Approval for a Medicaid Rehabilitation Option program for adults with severe and persistent psychiatric disabilities discharged or diverted from nursing home residential care including the use of Assertive Community Treatment (ACT) and Community Support Teams (CST).
 - Approval for an Autism Pilot Program for people with autism spectrum disorders without mental retardation, focusing on a coordinated system of supports and services including service coordination, supported living, supported employment and transportation.
 - Approval for a long-term care needs assessment of the unmet needs in the state and projections of the future demand for these services.
 - Approval for a Money Follows the Person Pilot to permit the legislative amendment of any Medicaid HCBS Waiver to accomplish the goals of Money Follows the Person.
 - Approval of an Accessibility Advisory Board comprised of design professionals, people with disabilities and people whose family includes persons with a disability.
 - Requirement that all state social service agencies assist housing authorities to identify and access services. This legislation also requires DMHAS, DMR and DSS to develop plans detailing their outreach efforts, available services and crisis intervention activities.
 - Expansion of the Supportive Housing Initiative for 500 new units by the end of SFY 2007.
 - Sustained the CMS-funded Nursing Facilities Transition Project as a state funded program and increased the amount of available funding for the program's operating expenses.
2. *An assessment of what is in place and working to rebalance the State's resources, i.e. to increase the use of home and community based rather than institutional, LTC services.*

Increased demand for community based services: In 1987, Connecticut's first Medicaid Waivers were approved. DSS implemented the CHCPE and a Waiver for people with intellectual disabilities, operated through DMR. In 1990, advocacy pressure resulted in closure of one of the two largest segregated training schools for adults with intellectual disabilities.

1991 Moratorium on expansion of new nursing facility beds: Successful implementation of the 1987 DMR waiver and the CHCPE provided evidence that people could safely receive long-term Medicaid services and supports in the community. By 1991, the growing demand for community alternatives changed the long-term projections for supply of institutional beds and the General assembly passed a moratorium on the expansion of new nursing facility beds. The moratorium marked the first significant rebalancing initiative, reflecting a philosophical shift from expansion of institutional care to expansion of home and community based care.

1997 Personal Care Assistance (PCA) Waiver: For the first time, this waiver provided community alternatives to people under the age of 65 and advanced the concepts of self-direction. Based on a fiscal intermediary model, the waiver gave control over hiring and firing of personal assistants to the consumer. Since 1997, the average monthly number of nursing facility days for Medicaid residents has dropped, even with added beds prior to the moratorium.

1999 Establishment of Long-Term Care Planning Committee: With the growing recognition of the need for coordination around long-term care planning, the General Assembly created the Long-Term Care Planning Committee (LTC Committee). Chaired by OPM, the LTC Committee represents key state agency leadership and legislators.

1999 Establishment of LTC Advisory Council, The Council is co-chaired by a legislator and the Commission on Aging and supports the LTC Committee. Membership of the Advisory

Council includes stakeholders such as providers, nursing facility industry representatives, consumers (both younger people with disabilities and older people), etc.

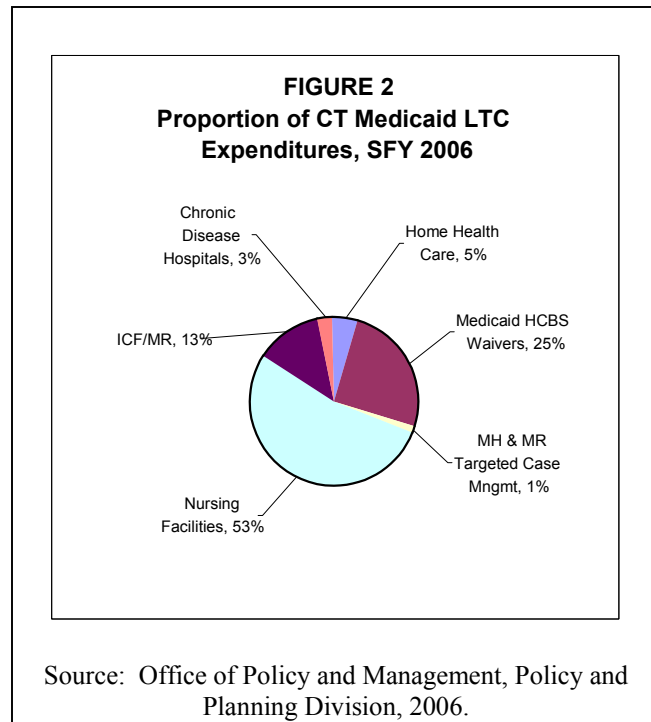
2004 Establishment of Connecticut's rebalancing goal: The long-term rebalancing goal for 2025 was set in the Long Term Care Plan for Medicaid recipients as 25% institutionalized and 75% would receive care in the community. The goal was forwarded to the General Assembly, and at that time, only 48% of the people were receiving community based care.

2001 Transition Program: Connecticut received a grant award from CMS in 2001 to develop, implement and sustain a transition system. Governed by a consumer-controlled steering committee, the system supports 6 full time staff in partnership with the ILCs and provides funding for transitional expenses such as initial household goods and furniture. This transition program became a permanent state program in 2004 when the 3-year federal grant ended. The program provides services for persons who have been institutionalized for more than 6 months and require assistance to return to the community. It plays a critical role in rebalancing by providing a choice to people who would have no choice than to remain in the institution.

No Waiting list policy for CT Home Care Program for Elders: As a result of increased demand for community-based care, a 'no waiting list' policy was established within the CHCPE. Noteworthy, is the Personal Care Assistance Waiver, which proved to be successful, so much so that more community slots were added in order to meet the increasing demand for services.

Closure of 2,500 beds: Since 1999, 2,500 beds have been removed from Connecticut's institutional long-term care system. Strategies have been implemented by DSS to ensure the health and safety of the persons in the nursing facility at the time of closure, which reduces the supply of beds in the system. Strategies vary based on many factors such as the need for beds in the geographic area, the balance sheet of the nursing home, the desirable number of beds per

room, the level of interest from potential buyers, etc. The past practice was to increase the per diem rates to assure the stability of the nursing home during transition, while locating an interested buyer. Today, it is more likely that a low census negotiation will result in a reduction



in the number of beds per room, the de-licensing of excess beds in the facility and facilitating transition to new ownership, or even the closing of the facility.

Coordinated Efforts to Disseminate

Information: In 2006, Connecticut launched a LTC website using tools from our statewide telephone information system, known as 211 Infoline, to provide information about LTC options. This effort,

combined with concerted efforts on the part of state agencies, the Commission on Aging, Real Choice System Change grantees, the ILCs and the Area Agencies on Aging, strengthens the infrastructure for the state's rebalancing effort.

3. *A description of current funding mechanisms, including those that restrict the flexible use of Medicaid funds to support individuals living in the community.*

Current funding mechanisms in the LTC system are varied, with Medicaid as the primary payer for LTC services. Other funds within the system include state funds, private payments, the Partnership for LTC, Social Services Block Grants, the Older Americans Act and the Rehabilitation Act. With Medicaid as the primary payer, it is necessary to get an understanding

of how the funds from this system are distributed in Connecticut. Figure 2 demonstrates the institutional bias in our current system.

Connecticut's budget: Connecticut develops, implements and monitors a gross budget; matching federal reimbursement on eligible Medicaid expenditures is posted as unrestricted revenue and becomes part of the State general fund. Budget estimates for Medicaid LTC expenditures are based on several factors including demand for institutional care, per diem bed costs, increased per diems due to low census, demand for state plan services and the number of state funded and Waiver program slots approved by the Legislature and Executive Branch.

Funding appropriated to a single Medicaid line on the state's budget: Endowments include state funded community support systems, including systems matched by CMS. Within the line, legislative caps on HCBS Waiver programs limit the number of people who can receive services. Each program is funded separately with different numbers of community slots, which may not be transferred nor reallocated beyond the cap to any other program without legislative approval.

Pooled Funding: DSS manages a pooled budget, where administration creates service estimates based on demand. This creates flexibility within programs, using demand to drive the requests for changes in administrative caps. Under this pooled budget approach, the system does not restrict the state's ability to rebalance. Services are accessible within available state funding.

4. A description of the various systems of care, waivers and SPAs that are utilized by the State to provide home and community-based supports and service

Systems of Care

The Connecticut Behavioral Health Partnership (BHP) is a system of care that provides coordinated, community-based, family-centered, culturally competent individualized supports for persons with psychiatric disabilities. Details are provided later in this section.

Medicaid State Plan Options Relative to HCBS:

Home Health Care: The majority of the formal home care services are provided by home health care agencies. There are 75 agencies licensed to provide home health care services in Connecticut. Services offered include skilled nursing, physical therapy, speech therapy, occupational therapy, homemaker/home health aide service and medical social services.

Durable Medical Equipment (DME): DME is equipment that can be used repeatedly for medical purposes. Medicaid will only pay for equipment that meets the definition of DME and is medically necessary. Although DSS has a list of DME for which it routinely pays, additional items may be approved for coverage and is considered on an individual need basis.

Rehabilitation Option for Psychiatric Rehabilitation Services (Rehab Option):

Adults: Connecticut currently covers rehabilitation services provided in mental health group homes of 16 or fewer beds as well as targeted case management (TCM) services to individuals with chronic mental illness. Services help clients access medical, social, educational and other benefits to ameliorate their symptoms and improve personal functioning.

Children: Under BHP, Connecticut provides case management and rehabilitation services through Early Periodic, Screening, Diagnosis and Treatment (EPSDT) authority when medically necessary to link medical, social, educational and other services. Services include a variety of psychiatric home-based rehabilitation and emergency mobile benefits.

Medicaid Waivers

Consumer Directed Services in Connecticut are administered by two different agencies, DSS and DMR, with DSS being the lead Medicaid agency. A brief description of each of the self-directed waivers follows:

Table 1: Connecticut's System of Home and Community-Based Service Waivers

CT Home Care Program for Elders	Serves 14,000 Elders age 65+ with a minimum of one ADL need area	Settings: Personal residences, Adult day care centers, Congregate housing, Elderly housing, Residential care homes, CCRC and MRC Assisted living, Alzheimer's facilities with private assisted living
Services: Adult day care, Adult day health care, Assistive devices, Assisted living services, Care management, Chore services, Companion services, Home health aide services, Home delivered meals, Homemaker services, Hospice services, Info & referral, MH counseling, Nursing services, Nutritional services, PCA services, Personal emergency response, Physical, speech, respiratory & occupational therapy, Respite care, Transportation		
Personal Care Assistance Waiver	Serves up to 698 adults with physical disabilities, self-direction	Settings: Personal residences
Services: Personal assistance services, Personal emergency response		
Acquired Brain Injury Waiver	Serves up to 369 adults with acquired brain injury	Settings: Personal residences, Group residences
Services: Case-management, Chore, Cognitive behavioral program, Community living supports, Companion, Day Habilitation, Durable medical equipment, Family training, Homemaker services, Home delivered meals, Independent living training, Personal care assistance, Personal emergency response, Pre-vocational services, Respite care, Substance abuse, Supported employment, Transportation and Vehicle modification		
Katie Beckett Model Waiver	Serves up to 180 individuals with physical disabilities.	Settings: Personal residences
Services: Assistive devices, Care management, Durable medical equipment, Home health aide services, Information & referral, Mental health counseling, Nursing services, Physical, speech, respiratory, occupational therapy, Prescription drug assistance, Transportation		
Individual/Family Support Waiver	Serves individuals with mental retardation	Settings: Personal residences
Services: Supported Living, Personal Support, Individual Habilitation, Adult Companion, Respite care, Personal Emergency Response, Home and Vehicle Mods, Supported employment, Group Day programs, Individual Day programs, Behavior/Nutritional Consultation, Specialized Equipment and Supplies, Transportation, Family Consultation/Support, Individual Consultation/ Support		
Comprehensive Waiver	Serves individuals with mental retardation	Settings: Personal residences, Community living arrangement, Community training home, Assisted Living
Services: Supported Living, Personal Support, Individual Habilitation, Adult Companion, Respite care, Personal Emergency Response, Home and Vehicle Mods, Supported employment, Group Day programs, Individual Day programs, Behavior/Nutritional Consultation, Specialized Equipment and Supplies, Transportation, Family Consultation/Support, Individual Consultation/ Support		

Additional HCBS Efforts: In addition to the existing waivers, legislative activity reflects a continued commitment to explore other home and community based options within the state. There are four population-specific pilots under discussion or development, which include individuals with autism, with mental illness, with multiple sclerosis and with HIV.

5. *Current expenditures on long-term and community-based care as well as other measures such as the number of institutional beds versus community placements*

During the fiscal year ending in 2005, Connecticut spent \$2,564,014,622 on long-term care. Of that amount, \$1,774,353,460 (68.95%) of the total LTC expenditures was attributed to institutional expenditures while \$799,661,162 (31.05%) was ascribed to community based care. Of the \$799,661,162, \$184,041,470 (23%) was certified to Home Health expenditures, \$428,875,342 (54%) was recognized as belonging to waivers serving DMR clients and \$92,431,576 (11%) arose from the CHCPE. The remaining 12% was found to be from combination of the PCA, the Katie Beckett and the ABI Waivers.

Of those served in the LTC system in 2005, 50% were served in the community and 50% were served in institutions. This is a significant shift from 2004, when 48% were served in the community while 52% was served in institutions. Though expanded HCBS options have increased the number of persons served in the community since 1999, the most dramatic growth is reflected in the CHCPE, which has experienced a 67% growth rate over 8 years and now provides services to 14,757 participants. The growth of HCBS as an option for persons with disabilities and elders has lessened the demand for institutional care. Medicaid recipients who were served in nursing homes dropped from 20,021 in 1999 to 18,857 in 2005, a 6% decrease.

6. *A description of any current efforts to provide individuals with opportunities to self-direct their services and supports*

Connecticut's HCBS waiver programs provide opportunities for participants to self-direct their services and supports. A brief description of these opportunities follows:

- **PCA Waiver:** Participants hire and manage their own PCA staff with a fiscal intermediary who administers for the PCA's payroll; the consumer establishes salary within budget caps. Training on managing PCAs is available for consumers.
- **ABI Waiver:** Participants or their conservators hire and manage their own PCA staff just as the participants in the PCA program; the two programs mirror each other. Participants are responsible for managing up to 20 additional home and community supports, depending on their level of need. Services are determined with the individual, a neuropsychologist, social worker and consumer-designated circle of support.
- **CHCPE:** The elder participant undergoes a holistic assessment conducted by professional to identify unmet needs and recommend supports. Whenever possible, the elder is regarded as "self directed" and is empowered to make adjustments in the frequency, duration and intensity of their services without prior approval. Connecticut also offers elders the option of self-directing personal care assistance which mirrors the PCA and ABI Waivers.
- **DMR Waivers:** Waivers permit consumers to hire people directly for many services, such as supported living and employment, respite, personal care, etc. Participants are provided with a fiscal limit where they can choose services in their customized package. DMR does not tell participants what services they can have and in what amounts as long as it stays within the budget limit and basic health and welfare needs are met.
- **Additional self-direction efforts:** All of the pilots under consideration include self-directed options for home and community-based services and supports.

7. *An overall description of any institutional diversion and/or transitions programs or processes that are currently in operation*

Preadmission Screening: Since 1987, Connecticut has operated a statewide preadmission screening program designed to offer home care as an alternative to institutional care. This activity is now linked with the preadmission screening process for mental illness/mental retardation (PASARR) so that every individual is screened prior to entry to a nursing facility. The Alternate Care Unit of DSS screens approximately 3,300 individuals per month.

Connecticut's transition program: Connecticut's transition program was initiated in 2001 with CMS grant funding.

- **Funding:** The original grant was funded at \$800,000 over 3 years, sustained by the General Assembly in 2004 for an additional 3 years with a 40% increase in 2006.
- **Management and Staffing:** The program is contracted to the Connecticut Association of Centers for Independent Living (CACIL), with a full time statewide coordinator and 10 full time transition coordinators, 2 at each ILC location.
- **Transition Coordinators:** Coordinators are responsible for 1:1 outreach, identification of residents, coordination of services and supports, location of housing, coordinating the move to the community and provide post transition supports such as instruction in independent living skills or case management up to 6 months.
- **Steering Committee:** The project is governed by a steering committee composed of 25 people that develop, implement and monitor the policies guiding the project. 51% of the members are seniors, people with disabilities, older adults and family members. State agencies, nursing facility administrators and providers are represented in the other 49%.

- **Data collection:** Consumer satisfaction drives Connecticut's transition system. Written surveys are mailed every six months to all who transitioned. Follow up phone calls are made to people who do not respond to the survey. Connecticut has followed every transition over the past 4 years and has found a very high (92%) satisfaction rate; there has been a 6% rate of return to institutions. 171 variables are examined on participants during transition, stored in a data warehouse and analyzed to determine the impact of barriers. Data-driven changes include prioritization of housing subsidies, accessibility modification funding and sustaining the CMS grant. Data sets from this system were used to develop the MFP gap assessment.
- **Transition Tools:** The project developed a series of tools for the MFP demonstration, including a Transition Guide, a self-assessment tool, a housing resource manual, quality management strategies manual for home and community based services and a "Common Sense Fund" for one time transitional expenses.

8. *An analysis of what shortcomings or 'gaps' in the system the State intends to address in the demonstration program*

Process for determination of gaps: Qualitative and quantitative data from the existing transition program identified factors that delay or prevent transition. Workgroups comprised of consumers, seniors, independent living staff, state staff and providers, analyzed the data. With the transition implementation workgroup in the lead, data and cases were studied over the past year to better understand HCBS systemic gaps that delay or prevent transition. The defined gaps were outlined in a paper, presented to the steering committee for approval and then presented to DSS as a set of recommendations for the MFP Demonstration.

Lack of affordable, accessible housing: Recognizing housing as a significant barrier, Connecticut's coordinated its transition system with the state's housing rental assistance program

and an accessibility modification program. This coordination will continue under MFP. DECD has committed \$1 million for housing modifications, while DSS plans to support 60% of the transitions with rental assistance. Despite the subsidies, transition coordinators continue to struggle with locating housing. To address this gap, the MFP demonstration will hire 5 FTE housing coordinators and will coordinate with DECD's newly established housing registry of affordable and accessible housing, to be fiscally sustained by DECD. The DECD letter of partnership is included in Required Endorsements.

Lack of information for conservators and attorneys: After housing, the greatest barrier affecting time to transition is conservatorship. Conservators often misunderstand roles or the principles of self-determination and choice. Often attorneys are involved either serving as the conservator or serving indirectly as the counsel. The Elder Law Section of Connecticut's Bar Association has agreed to provide outreach and education to its member attorneys. A letter of agreement from the Elder Law section of the Bar is located in Required Endorsements.

Lack of integration of assistive technology (AT): AT is any device or service that can aid a person to maximize their independence. During the post transition phase, the absence of appropriate AT is a documented barrier, but Connecticut does not have sufficient data relative to the successful integration of post transition assistive technology. This gap will be addressed within MFP by coordinating with the State's Assistive Technology equipment loan programs. AT needs of participants will be identified, AT trials given and data will be collected relative to the utilization of technology. Successful trial periods will be followed by the purchase of appropriate technology within Medicaid allowable limits. Connecticut will use this data to guide future waiver and/or state plan development.

Lack of access to information: This rebalancing strategy is dependent upon access to information about community-based options. Connecticut has a strong transition system but for rebalancing to occur, additional transition coordinators will be required. Experience has demonstrated that a 1:1 outreach ratio is the most effective strategy. The existing system utilizes the state's ILC network, aligning federal funding streams with Connecticut priorities such as information and referral regarding community choices. The Older American's Act also has federal funding mechanisms for information and referral. Connecticut's MFP proposal seeks to expand transition services to include the network of AAAs.

Waivers based on specific disability rather than functional need: Data collected through the existing transition system identified gaps within Connecticut's existing community-based service system. Currently, Connecticut has 6 waivers in place and 4 under development. Waivers specific to diagnosis rather than functional limitation prevent many people from successfully transitioning to the community. There are also service gaps in existing waivers.

Lack of coordinated strategies for quality management: Each of Connecticut's HCBS Waiver programs have quality management components in place. MFP will add a coordinating effort to ensure necessary information is shared across components focusing on improvements made to the delivery of the services to the consumer.

9. *An analysis of what collaboration among the various programs in the State is necessary to ensure the success of the demonstration program.*

Ensuring access to the demonstration through information and referral: The ILCs and AAAs will collaborate with each other and with the project staff. Their focus in the project will be the entry points to the demonstration by ensuring outreach to nursing facility residents. The LTC Ombudsman will also facilitate access to information in nursing facilities, assisted living

and Residential Care Facilities. This program is a full partner in the transition system. Letters of support from these partners can be found in Required Endorsements.

Ensuring access to waivers and state plan services: Coordinators will collaborate with DSS and DMR in their administration of the various waiver programs including DMHAS in their role with community based services. Within state agencies, additional collaboration is required since waivers and other HCBS programs are administered in different units.

Ensuring access to housing: Collaboration between housing and waivers is critical to success of the demonstration. Housing and community services must be in place on the day of discharge.

- **Rental Assistance Program:** Collaboration will be required with various housing programs. DSS serves as the State Housing Authority and administers a statewide Section 8 program funded by HUD, as well as a Rental Assistance Program that provides access to housing subsidies in the absence of federal funding.
- **Housing Registry and Housing Modification Program.** This MFP demonstration will partner with DECD on its web based housing registry, targeted for completion in June 2007. Staff from the MFP project will support the success of the registry by enrolling landlords. Successful implementation of the accessible housing funds will also require collaboration.

Ensuring access to additional LTC programs: A successful demonstration is also dependent upon collaboration with a variety of additional programs within the state.

- **Department of Social Services:** The proposal will coordinate with a variety of programs, including the respite care, assistive technology, the Alzheimer's programs, Food Stamps, Caregiver Support, Title III B Supportive Services managed by the Area Agencies on Aging, Community Based Services, Essential Services and expansion of transportation programs. DSS houses the Vocational Rehabilitation Program and the Medicaid Infrastructure Grant

(MIG), providing the MFP with a unique opportunity to establish shared goals with the MIG and the MFP for participants with employment goals.

- **Department of Mental Health and Addiction Services:** The MFP proposal will coordinate with Local Mental Health Authorities to provide support in the community for people with substance abuse or mental illness and Club Houses to provide social opportunities and peer support for persons with mental illness.
- **Department of Mental Retardation:** The MFP proposal is intricately linked with the DMR operated waiver programs and their quality framework will serve as a foundation for MFP.
- **Board of Education Services for the Blind:** The MFP proposal will link with the Vocational Rehabilitation program, as well as the elder blind program to provide access to specialized supports for individuals who are legally blind.
- **Department of Transportation:** The MFP proposal will line with the United we Ride Program to address transportation issues for participants.

10. *What systems, procedures and policies are in place to monitor and address, (i.e., track, identify and correct) deficiencies related to quality assurance for eligible individuals receiving Medicaid HCBS and provide for continuous quality improvement in such services.*

DSS has a comprehensive quality improvement plan reflecting CMS' Quality Framework and is in the process of evaluating the frameworks for each of the Medicaid Waivers. The CHCPE Quality Improvement program has four teams in place to provide ongoing monitoring, including the Quality Review Team, Peer Review Team, Report Team and the Training Team. All care plans are reviewed and "outliers" are identified for follow up. The Quality Improvement Program also includes Outcome Indicators to evaluate the impact that services have had on individuals such as quality of life, health and safety and consumer satisfaction. DSS conducts

regular client satisfaction surveys, perform record reviews of contractors, handles administrative reviews of provider requirements, monitors compliance with reporting requirements and holds face-to-face client and provider visits. Ongoing Quality Improvement activities include in-service trainings, regional information meetings and collaborative training programs. The Quality Management Program also includes maintenance of a complaint log and a log of health and safety concerns.

11. *What State legislative and other changes are necessary (and accompanying timelines) to implement the MFP demonstration.*

Connecticut anticipates the following legislation to fully implement the MFP demonstration:

2007 legislative considerations: Connecticut's General Assembly passed legislation during the 2006 session permitting DSS to submit the MFP proposal for 100 people. Recommended legislation to support this MFP proposal includes:

- Increase in the capacity of the HCBS Waivers to serve all demonstration participants
- Increase in the RAP to provide state funded housing subsidies to those transitioning
- Increase in capacity of existing HCBS waivers

2008 legislative considerations: Service gaps identified within this proposal require the development of expanded home and community based services.

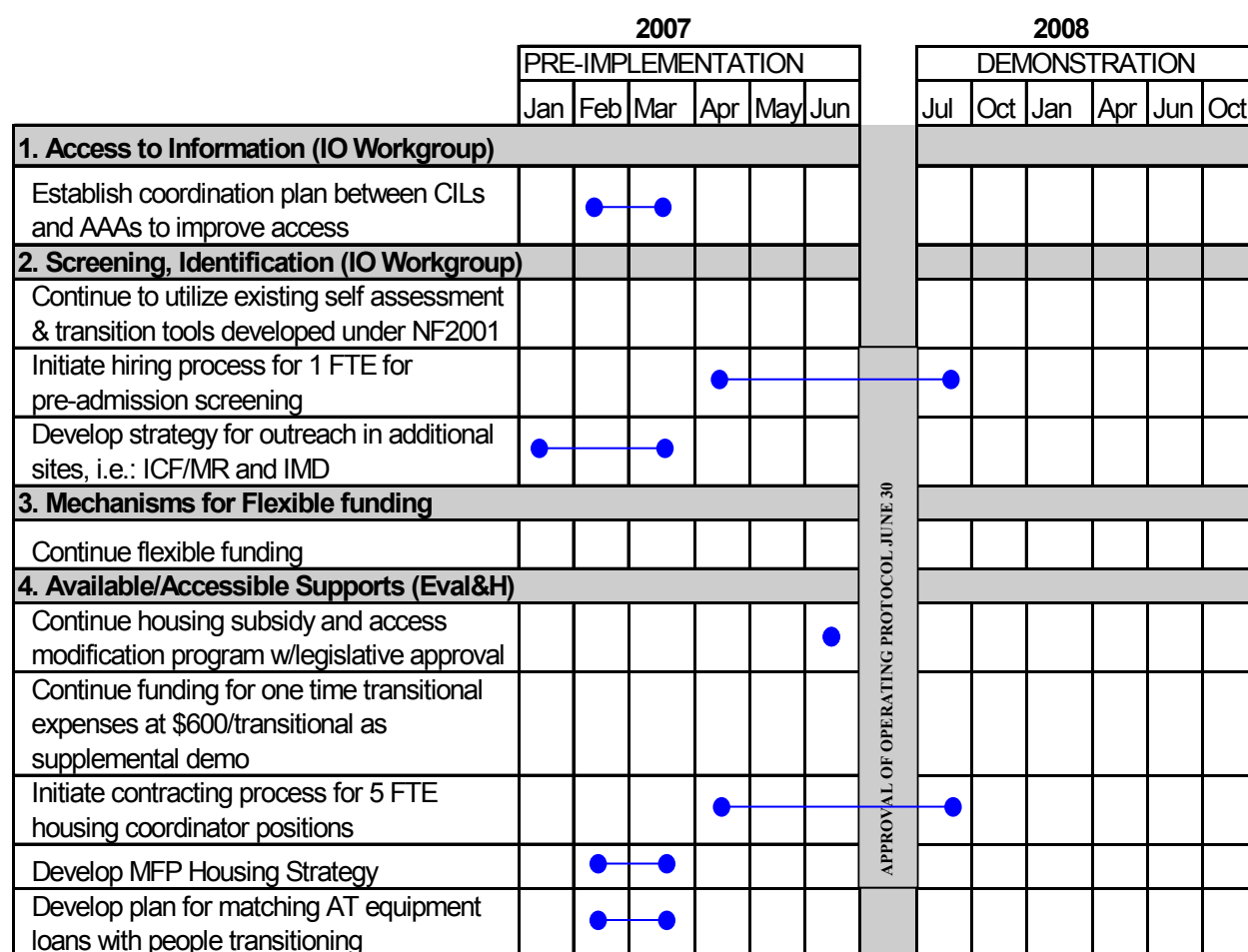
- Recommendation for approval of an 1115c demonstration.
- Recommendation for approval of SPA personal care option
- Recommendation for an increase in capacity of existing waivers.

2009-2011 legislative considerations: Connecticut anticipates amendments during this time period to increase the number of slots in waiver programs depending upon demand.

Part 2: Demonstration Design

1. The Pre-implementation Phase, including the interventions and length of time expected to put in place the infrastructure needed (including legislation) to expand their community-based LTC capacity and sustain the demonstration participants in community-based care settings.

The following chart depicts Connecticut's overall plan and timeline for implementing MFP.



Connecticut's MFP Demonstration

	2007						2008					
	PRE-IMPLEMENTATION						DEMONSTRATION					
	Jan	Feb	Mar	Apr	May	Jun	Jul	Oct	Jan	Apr	Jun	Oct
5. Community Workforce												
Continue to develop PCA registry	●					●						
Continue funding of advertisements for PCAs as supplemental demo	●					●						
6. Self-directed services (TI Workgroup)												
Continue existing self-directed waivers												
Request legislative approval to increase capacity of existing PCA and CHCPE waivers supporting self-direction	●											●
Finalize waiver or SPA application for package of services for persons w/MH dis.				●		●						
Identify appropriate waiver or SPA for implementation		●	●									
Design, develop and request legislative approval of new waiver or SPA; Hire 1 FTE					●						●	
7. Transition Coordinators (Admin)												
Continue existing transition positions with 5 CILS	●											●
Initiate hiring process for 1 FTE for technical assistant				●			●					
Establish contracts with 5 AAAs		●										●
8. Quality Management (QM)												
Continue AM in existing waivers												
Develop strategy for integrating demo												
9. Health Information Technology (Admin)												
Continue to utilize data warehouse and existing NF database												
Develop identifiers for tracking transitions in data warehouse and generating reports	●		●									
Develop billing and coding process for demonstration and supplemental services	●		●				●					
Develop plan for IT support to CILS & AAA	●		●				●					
Develop plan for managing QM information	●		●				●					
10. Cultural Competence												
Continue existing staff diversity training including disability culture							●					
11. Interagency and Public/Private Collaboration (steering committee)												
Continue and expand existing NF governing steering committee model												
Identify workgroup participants and initiate meetings in January	●											
Review first draft of plans from each workgroup			●									
Approve plans for operating protocol				●								
Submit operating protocol to CMS					●							

APPROVAL OF OPERATING PROTOCOL JUNE 30

With an existing transition system, flexible financing, coordinated housing subsidies and capacity in all waivers, Connecticut could begin implementation upon receipt of the award by improving and expanding upon the existing system. Interventions to address gaps identified in Part 1 of this proposal will be developed by workgroups which include stakeholders containing members of the steering committee, providers, consumers, nursing facility administrators, ILC and AAA representatives and state agency representatives. Draft plans will be submitted to the steering committee in April with a final approval targeted for May. Connecticut plans to submit the jointly designed operating protocol to CMS in May and target July 1 for implementation assuming the protocol is approved. Working together, the teams will create an enhanced system consistent with the principles of Money Follows the Person. A brief description of pre-implementation interventions is as follows:

1. Access:

Connecticut is one of the few states without an Aging Disability Resource Center. While the MFP demonstration does not afford the opportunity to shift the primary focus to the development of an ADRC, it does present the ability to improve coordination and capacity between the AAAs and the ILCs as entry points. Both community-based organizations receive federal funding to provide information and referral regarding the long-term care system. The MFP will fund full time transition coordinators, provide technical assistance and support monthly collaborative sessions. The Information and Outreach committee will begin meetings in January to discuss a coordinated plan. The plan will create a stronger entry point with dedicated staff providing systems navigation to aid people in making their choice to move to the community through successful implementation of a care plan. The coordination plan will be submitted to the steering committee to give its approval in May. Though this increased access is limited to those

who are interested in MFP, the increased capacity and coordination between CILs and AAAs has a broader application for the future development of a comprehensive ADRC.

Outcome: Intervention in place July 1.

2. Screening, identifying and assessing:

Transition Coordinators One to One outreach: Transition coordinators provide access to information about community options on a one to one basis to residents in nursing facilities. Other strategies involving outreach materials did not provide evidence of being effective.

Referrals from Nursing Facilities, family members and 'self-referrals': Realizing the importance of one to one outreach and the large number of institutions, strong collaborative relationships have been built with nursing home social workers to aid with the identification of residents who desire to move to the community. Social workers in nursing facilities are an integral resource in the process since they are known and trusted by the residents. Other types of referrals originate from family members or are self-referrals. While this process for identification is effective, Connecticut plans to make improvements by creating another strategy utilizing the preadmission screening tool.

Utilization of preadmission tool for identification: The screening tool will be modified to include additional information relative to many factors that may lead to a long-term institutional stay. A plan for coordination and communication between transition coordinators and preadmission screening staff will be developed. The Information and Outreach workgroup will begin monthly meetings in January. The draft tool and plan will be given to the steering committee for approval in May. The hiring process for 1 staff person dedicated to the preadmission screening tool will begin in April. Connecticut will continue to use the self-

assessment tool, self-directed guide to transition and the guide to finding a home created by the 2001 NF grant. **Outcome: Additional staff in place July 1; Tool modified Sept 1.**

3. Available and Accessible Supportive Services

Waivers and State Plan Services: The framework of an effective community based support and service system is already in place in Connecticut. While there are gaps as documented in this proposal, Connecticut has the capacity within its existing HCBS infrastructure to begin the MFP demonstration the day that the operational protocol is approved. Connecticut has a wide array of community-based services for persons on Medicaid over the age of 65. For persons with a brain injury or with mental retardation, there are self-direction options and other packages that include up to 21 services. For persons with a physical disability there is a personal assistance waiver. Connecticut does not presently offer a range of services for all people with disabilities under the age of 65; there are many who do not have a brain injury or mental retardation for whom the personal assistance waiver alone is inadequate. People with multiple sclerosis may require the services of a personal manager to direct support services. Connecticut does not currently offer live in services for any targeted population and plans to address service gaps that prevent people from having access to HCBS during pre-implementation. The proposed service packages are included in this proposal. During pre-implementation, an 1115C waiver and personal care State Plan Amendment will be developed. Approval is expected within the first year of the demonstration. The new service package will be based on functional limitation rather than disability. Connecticut expects its new mental health waiver or SPA to be finalized during the same period. The new qualified service package will give people with disabilities not currently covered through the current package, the choice to live in the community. The waiver draft will be approved by the steering committee in April. Connecticut plans to negotiate implementation

of a new service package with CMS so that the new services can begin upon approval of the operating protocol. Meanwhile, the approval of waivers to sustain services after the demonstration year can go on concurrently. The process from design to implementation of the new waiver and SPA is expected to take 1 year and will also require changes to Connecticut's legislation in order to accommodate expansion in 2008. The General Assembly will act annually on recommendations from the MFP for expansion of slots and services in existing waivers beginning in 2007 subject to appropriations. **2007 recommendations: Expansion of MFP legislation to demonstrate up to 150 transitions per year; Expansion of slots in PCA and CHCPE**

Housing: Connecticut has key agreements in place to address housing barriers. Housing subsidies and accessibility modification funds are coordinated with the transition system providing the widest range of housing to people transitioning. This coordination will continue under MFP. Letters of endorsement indicating the intent to provide \$1million for accessibility modifications and rental subsidies for 70% of the persons transitioning are attached. State housing funds will also follow the person to the community.

Despite the housing subsidy programs that Connecticut has in place, finding accessible affordable housing remains problematic and takes a significant amount of the transition coordinators' time. For this reason, Connecticut plans to add 5 contracted housing coordinators to assist the coordinators in the housing search. These full time positions will also be coordinated with the housing registry that will be functional in June. Housing coordinators will identify housing and get agreements from landlords for uploading information regarding registry units. Development of a comprehensive housing strategy is essential to the MFP. The aforementioned components are part of an overall strategy that will be developed by the housing workgroup. A

needs assessment has already been completed in Connecticut relative to affordable housing. The Governor's Task Force on Affordable Housing is completing its recommendations for consideration of the 2008 General Assembly. The MFP workgroup will review recommendations and determine viable options within the MFP demonstration. The housing workgroup will draft its strategic plan for addressing the housing shortage relative to persons transitioning for the steering committee's approval in May. **Outcomes: Housing strategy implemented July 1; Legislation in 2007: Request increase appropriation for RAPs.**

Assistive technology (AT): AT is another identified gap in Connecticut's HCBS system. To address this gap, a partnership between Connecticut's Assistive Technology project and the transition program was formed. The equipment loan program will provide transitioning individuals from nursing homes with an opportunity to use equipment thereby determining its appropriateness prior to purchase. The AT program will also provide 'Tech Mentors' to assist with teaching people who are transitioning how to use equipment if necessary. 'Tech Mentors' are peers with experience in assistive technology. With the pace of change in technology, much more can be done to successfully integrate AT into a care plan. For those transitioning, data will be collected regarding the impact of AT on the level of independence, enhanced self-direction, consumer satisfaction, costs of personal care (and other fiscal impacts), participation in community, connections to employment, etc. UCONN Center on Aging will lead this evaluation under the guidance of the evaluation workgroup. A full description of the implementation and an evaluation plan will be included in the operational protocol.

Outcomes: Assistive Technology program implemented July 1 with evaluation.

Self-direction: As previously stated, Connecticut has several gaps in the existing system to deliver self-directed services. The steering committee is in agreement about the design and

implementation of a cash and counseling model as a component of the 1115C Demonstration waiver as well as a component of the PCA SPA. The transition implementation workgroup will begin monthly meetings in January for the purpose of assisting with the design of the new HCBS models. Connecticut will have a continuum of LTC options supporting the highest degree of self-direction. **Models will be completed and recommended to the General Assembly in 2008. Increases in the capacity of existing waivers will be recommended during the 2007 legislative session. Expansion of service menus for PCA and CHCPE will be considered based on remaining documented gaps, during the 2009 legislative session.**

Quality Management While the waivers under administration of the DSS all have quality management mechanisms in place, there is no formal mechanism for sharing information. The MFP will create a QM committee. The committee will be responsible for developing a QM strategy. The UCONN Center on Aging will support the demonstration by collecting information relative to consumer satisfaction and other quality indicators. The detailed plan will be presented as a draft to the steering committee in April with final approval in May. The approved plan will be submitted as part of the operating protocol. **The new QM strategy will begin July 1 subject to approval of CMS.**

Health Information Technology: Connecticut has the capacity to report information on persons under the MFP Demonstration. The existing MMIS system and the data warehouse provide essential information on persons within the existing transition system. Total Medicaid utilization and LTC expenses are presently analyzed on a quarterly basis to inform change. Quality indicators are stored in a separate warehouse. A Microsoft Access database is used presently to perform statistical analysis including quality management functions of the transition program. While capacity exists to implement MFP, a process must be developed to capture and report

financial information specific to the demonstration and quality management information. A system linking both the AAAs and the CILs to the DSS will be created. **This plan will be developed by the administration and included in the operational protocol for July 1 implementation.**

Ongoing: Interagency and Public/Private Collaboration

Steering Committee: Collaboration with Oversight: Connecticut's success in sustaining the initial NF transition program was largely attributed to the level of interagency collaboration and public private partnerships exemplified within its consumer controlled steering committee/workgroup design. Initiated under the Real Choice Systems Change NFTG in 2001, the committee is currently co-chaired by a state agency representative from DMHAS and a person who transitioned from a nursing facility. The steering committee was recognized by the Americans with Disabilities Act Coalition of Connecticut in 2005 for exemplary leadership. The model was selected as the subject of a web conference by the National Conference of State Legislatures and the theme of the first HBCS Clearinghouse for the Community Living Exchange Collaborative News Clip. The diverse steering committee had a key role in the development of this proposal. The Nursing Facility Transition Steering Committee will become the MFP Steering Committee and govern the activities of the MFP project. All aspects of the MFP will be designed, developed, implemented and evaluated by workgroups; status updates will be presented to the steering committee monthly. The Steering Committee has decision-making authority.

2. The Implementation Phase, including the population(s) to be served (including the minimum length of time they have received institutional care), the number of individuals the State will transition, the site(s) of the demonstration, the institutions from which they will be transitioned, the "qualified residences" to which they will be transitioned and the services that

they will be offered broken down according to the chart in section 2A, Fundamentals of the Demonstration.

Population to be served: Connecticut will outreach to all populations including children, older people and persons with disabilities including but not limited to persons with intellectual disabilities, physical disabilities and mental health disabilities.

Number of Individuals transitioned: Connecticut plans to transition 700 people from institutions over the five-year demonstration. Of the 700 transitions, 40% will be targeted as elders, 20% will have a physical disability, 20% will have mental illness, 10% will have mental retardation and 10% will have multiple disabilities.

Sites of the demonstration: Connecticut plans to outreach in all demonstration sites to identify and assess persons who would like to live in the community. Demonstration sites include skilled nursing facilities, intermediate care facilities for persons with mental retardation, hospitals and institutions for mental diseases as allowed under the state plan.

Qualified residences: Connecticut plans to provide the maximum choice possible to persons transitioning from nursing facilities. Each eligible individual or the individual's authorized representative will choose the qualified residence in which the individual will reside and the setting in which the individual will receive home and community-based long-term services.

- 1) Home owned or leased by the individual or the individual's family member; affordable apartments and homes will be identified in geographic locations selected by the consumer. The housing registry will help identify units available and access in the state. To date, the transition coordinators have had this responsibility and have successfully used their existing community networks.

- 2) Apartment with an individual lease, with lockable access and egress and which includes living, sleeping, bathing and cooking areas over which the individual or the individual's family has domain and control: Connecticut plans to offer assisted living options under this section. Noteworthy, home health agencies are licensed to provide care in assisted living communities but the person living in the apartment has the choice of accessing the home health agency in their community or choosing another agency. Management of the apartment is separate from the health care agency. Leases are signed between the tenant and the landlord. Assisted living is a desirable choice for many older people.
- 3) Residence in a community-based residential setting, in which no more than 4 unrelated individuals reside; Connecticut has several living arrangements for people with disabilities. MFP will offer the broadest array of options possible under the Act.

3. Anticipated requests for the waivers *necessary to operate its program, including modifications to existing waivers and State plan amendments:* Connecticut plans to address the service gaps in the existing system by simplifying access to community-based services. The steering committee has spent many years analyzing the data from the existing transition project. On a first come – first serve basis, transition coordinators have attempted to transition anyone who expressed an interest in living in the community. The absence of HCBS for people who did not fit the eligibility criteria of the existing array of services was significant. While admitted into the transition system, the barriers to transition were documented and these people remain institutionalized. The absence of supports for certain people was so bothersome, that the transition implementation workgroup of the steering committee wrote a white paper detailing the absence of services and a recommendation. The recommendation was received by the steering committee and became the basis for the enhanced self-directed system reflected in this MFP

proposal. A single cross-disability waiver or state plan amendment is envisioned based on functional need. Final details will be determined in the pre-implementation phase. **A new qualified plan will be prepared as a recommendation to the General Assembly in 2008. Amendments expanding services to existing waivers are envisioned. Expansion of slots will also be recommended during the 2008 legislative session. Services within existing waivers will be recommended during the 2009 legislative session.**

Connecticut's proposed demonstration services for MFP are outlined in the chart below. The demonstration services are services that are currently outside of an existing qualified HCBS program. Connecticut plans to begin revealing these services as negotiated with CMS during the pre-implementation phase of the demonstration and plans to have an 1115C waiver and a state plan amendment in place to sustain services and address service gaps by the end of the 12-month demonstration. For the most part, the wide range of qualified services is currently available in the DMR, CHCPE and ABI waivers. During year 1, Connecticut will begin demonstration with existing services. In year 2, the list of qualified services will be offered as part of the MFP demonstration. In year 3, the service package will formally become part of an 1115c waiver to address the gaps that currently exist and prevent persons with disabilities from transitioning to the community. Additional detail regarding HCBS may be found in the State Profile.

Connecticut's MFP Demonstration

Qualified HCBS Program	HCBS Demonstration Service	Supplemental Demo Services
Chore Services		5 Housing coordinators
Cognitive Behavioral Service		
Companion/PCA		
Community Living Support Program		
Consultative services		
Environmental Modifications		State level Evaluation
Family Support and Psychosocial education	Post transition services for up to 12 months	'One Time' Transitional costs
Home Delivered Meals		Assistive Technology
Homemaker Services		Home Accessibility Modifications
Independent Living Skills Training		
Mobile Crisis Assessment/Stabilization		
Personal Care Assistant		
Peer Support		
Personal Emergency Response System		
Personal/Financial Management		
Pre-vocational Services		
Respite		
Transportation		
Service Coordination/Care Management		
Substance Abuse Programs		
Supported Employment		
Support services: Assistive Technology and Materials		
	24 hour 'live in' support	

4. A description of methods *that will be used by the state for each fiscal year to increase the dollar amount and percentage of expenditures for HCBS*

Connecticut's budget methods support flexibility with respect to estimating demand for services based on the needs of the people. The Long Term Care Planning Committee (LTCP) establishes the rebalancing goal for the state and the 2025 goal currently is set at 25/75 whereby 25% will remain institutionalized and 75% receiving Medicaid LTC services will receive care in the community by 2025. During fiscal year ending 2005, the rebalancing goal was advanced significantly from 48 HCBS/52 institution to 50 HCBS/50 institution. Activities to advance the goal are assigned to the various departments of state government represented on the LTCP. Annual status updates provide the General Assembly with information relative to advancing the rebalancing goal. The goal does not drive the budget, rather, the goal drives objectives and activities within the state designed to increase HCBS awareness and remove barriers to choice. Estimates for HCBS each year are based on historical trends with estimated additional growth attributed to interventions. The methods to achieve the goal will continue to be based on increasing supply to meet future estimated demand. Connecticut will assure adequate capacity in HCBS in order to meet the increased demand attributed both to MFP interventions targeting people living in institutions as well as the heightened awareness of HCBS as a choice for those at risk in the community. Methods for increasing the dollar amount and percentage of expenditures for HCBS relative to institutional expenditures are as follows:

- Assure access to information about choice and a range of appropriate HCBS
- Analyze historical trends
- Estimate impact of MFP interventions on trends
- Project change in trends based on impact analysis

- Assure adequate HCBS capacity
- Increase caps based on demand.

5. A list of proposed benchmarks *to establish empirical measures to assess the State progress in rebalancing its long-term care system.*

Connecticut plans to have 20 transition coordinators in place by 2009. Participants in the MFP program will continue to have access to housing subsidies and accessibility modifications.

Recognizing that the location of housing is the most difficult challenge during the transitioning phase, Connecticut plans to address this through hiring 5 regional housing coordinators. The planned number of transitions are cautious over the 5 year period of the MFP. Additional workforce capacity must be aligned with the transition benchmarks in order to assure safe transitions and strong back-up PCA plans.

Year	% of Long Term Care Institution	% of Long Term Care HCBS	\$ Increase in state Medicaid Support for HCBS	Number of eligible individuals assisted to transition
2007	50	50	\$874,000	50
2008	49	51	\$5, 719,000	100
2009	47	53	\$10,923,000	150
2010	45	55	\$19, 265,000	200
2011	42	58	\$19,576,950	200

6. Processes for how the State *intends to target and recruit individuals to transition from institutional settings to the community, including specific strategies and procedures*

One to One - Referral

The State of Connecticut has implemented a transition program for over 5 years that specifically targets people who are Medicaid eligible and who have been in nursing facilities for 6 months or greater. The most effective methods to seek out persons interested in transitioning to the community have been 1:1 outreach in the nursing facility. The transition program coordinators have established positive relationships with nursing facilities. Referrals are made on a regular basis to the program which has a waiting list of 22 people.

Relationship with nursing home industry

With the implementation of MFP, DSS will continue to work in conjunction with the nursing facility associations. As in the past, state agency staff will meet with the associations and communicate plans regarding outreach. Outreach materials and letters to nursing facility administrators will be sent to the association first so that they are informed and can answer any concerns expressed by their membership. Subsequent to informing the associations, DSS will mail administrators, discharge planners and social workers in all nursing, ICR/MR and IMD facilities the correspondence informing them about the expanded transition program and the role of the transition coordinator. Transition coordinators will establish a presence in the facilities and will meet with social workers and residents councils. Recommendations from staff, ombudsman and self-referrals are expected. Outreach materials have already been developed. In the case of persons with Mental Retardation, a list has already been established identifying people who would like to move to the community.

Preadmission Screening

The operating protocol will detail the specific details of a new strategy for identifying individuals who may be interested in returning to the community. The preadmission screening

modified tool that Connecticut plans to implement will provide additional information about persons admitted to a nursing facility who are at risk of a long-term stay. A coordination plan between the preadmission data staff and the transition coordinators will provide an additional means for identifying persons eligible for transition under MFP.

Assessment

Connecticut implements a self-assessment process. A tool was developed under the 2001 NF grant. To the maximum degree possible, the resident completes the assessment and begins the process of anticipating what support they will need in the community. This process will be replicated in ICF/MRs although it is anticipated that some additional assistance may be required with the self-assessment. After self-assessment and prior to intake into the demonstration, transition coordinators will use appropriate and thorough informed consent. Where appropriate, conservators or guardians will be included. A successful outreach and fair method of informing people of their choice will be exemplified by the diversity of those transitioned.

7. A description of the cross agency and cross service delivery system collaboration that will need to occur to ensure success of the State's transition program.

Connecticut's grant application was prepared through collaboration with the consumer controlled Nursing Facility Transition steering committee, the leadership of the DSS and the general public through a statewide public forum. The Transition Implementation Workgroup (TI) of the steering committee completed the assessment of unmet needs and gaps in the state located in Appendix 6. The TI workgroup is comprised of representatives from DMHAS, the coordinators from each ILC, providers and waiver managers from DSS. Experience over the past 5 years has established the essential nature of coordination between the transition coordinators, waiver program managers and staff and housing programs. These groups continue to meet once per

month and have communication between meetings on a regular basis. This collaboration will continue as Connecticut expands the program and awareness of community based services. The Nursing Facility Steering Committee has agreed to become the MFP Steering Committee

Quality Management and increased capacity of waivers: All waiver managers had input into the design of the quality management section of this application and in the newly envisioned package of services. The Director of the State's Unit on Aging who has oversight of the ABI waiver and the PCA waiver drafted the quality management section of this proposal. This section was reviewed by both the Manager of Alternate Care (oversight of CHCPE) and the Director of Strategic planning from DMR (oversight DMR waivers). Target populations for the demonstration were discussed with all relevant agencies. All agencies have agreed to assist with the transitions of persons into their respective waivers, during the demonstration year and in the years to follow. Commitments have been made regarding collaboration across waivers on the important element of quality management. The MFP demonstration requires a high level of coordination between all waiver managers. Letters of support from all state partners operating waivers or HCBS are attached.

Transition from Nursing Facilities: Both AAAs and ILCs were involved in the drafting of this proposal through representation on the steering committee. Each of the five AAAs and five ILCs has agreed to participate in the demonstration by dedicating 2 FTE transition coordinator positions to the MFP. In addition to dedicated staff, successful transition requires coordination with the nursing facilities, the provider networks, conservators and the waiver programs of the state. The Transition Implementation committee was established to address the high level of coordination involved with all of the aforementioned partners. Through monthly meetings

specifically designed to discuss barriers to transition, the group will continue in the MFP to jointly design solutions.

Identification of Residents: Connecticut continues to enjoy a good working relationship with both the nursing facility industry and the statewide association of Social Workers. This collaboration helps to ensure the success of the program in many ways. Discharge planners and social workers inside nursing facilities are both key partners with transition and can shorten the time it takes to transition a person significantly.

Housing Shortage: Connecticut plans to continue its 5year history of successful collaboration in addressing the housing barriers for persons transitioning. Partners for Connecticut's demonstration include DECD, the state Rental Assistance Program, Local Housing Authorities and the Corporation for Independent Living. DECD has agreed to partner with the newly created Housing Registry and the accessibility modification program. The RAP has agreed (subject to approval of the General Assembly) to continue offering rent subsidies to those transitioning in the absence of housing vouchers. The Corporation for Independent Living operates both components of the AT equipment loan program and the transition program accessibility modification program. All partners were involved in this proposal and are prepared to assist within the aforementioned roles during the demonstration. Letters of intent on the AT Partnership, the RAPs and the accessibility modification funds are attached.

Assistive Technology: The AT program coordinator was involved in the design of this proposal. Agreements to partner regarding the equipment loan program and the Tech Mentor program have been discussed and are in place. Details relative to this will be included in the operating protocol. A letter of endorsement is included in this proposal.

Reporting fiscal information and budget methods: DSS is a large agency in Connecticut.

Grant reporting and budgets are generally centralized within the unit implementing of the grant.

MFP, however, is based on a reimbursement methodology which requires the involvement of the fiscal unit of the department. Successful coordination is imperative.

Other Community Programs: Many other programs at a community level are involved for successful implementation of MFP. From providers of HCBS, to the telephone company, to the people delivering the bed to the new apartment, successful implementation requires the ability to coordinate and collaborate with many public/private partners.

8. A description of the “qualified home and community-based program” *which will be available to individuals following the year they receive services through the demonstration program.*

- DMR will continue to operate 2 waivers. These waivers are designed with the Independence Plus template and offer a wide range of self-directed services to the population of people with mental retardation.

The DSS will continue to operate the CHCPE waiver, the PCA waiver, the Katie Beckett waiver and the ABI waiver. Assistive Technology services will be integrated as a supplemental service with the CHCPE waiver and the PCA waiver during the demonstration.

- DMHAS will have a HCBS service package in place as indicated on the state profile.
- All eligible persons will have access through the new waiver to the wide range of services listed as qualified services. In addition, 24 hour live-in will continue as a service in the waiver. This waiver will address the service gaps defined in this proposal. This new alternative will display a high degree of flexibility and choice, offering consumers the highest degree of self-direction. Individual budgets will be established based on level of need and

consumers and/or their representative will select from the menu services that best meet their needs. As previously stated, Connecticut plans to incorporate Cash and Counseling into the new waiver. This option will be available for persons of all ages and eligibility will be based on functional need rather than disability.

Additionally, state plan amendments are anticipated as follows:

- A personal assistance state plan amendment will be in place in year 3.

Other state plan services such as Home Health will continue to be part of Connecticut's package of community services. All descriptions of future waivers and state plan amendments are subject to approval of the General Assembly.

9. A description of the State's preliminary design of a proposed Quality Management

Strategy that encompasses both the program participants and the qualified home and community based program that will be in place when the demonstration is finished.

Overview of the Quality Management Plan

This Money Follows the Person Grant is designed to assist Connecticut residents across disabilities and focus on functional limitations. In the same way as the state intends to work across disabilities, this grant will provide quality management services across waivers and across state funded services/programs. Connecticut intends to use the guidance provided under the 1915 (C) waiver applications as the basis for the design of the quality management system for this grant. Connecticut intends to continue the operation of all of its waivers to support the people transitioning from nursing homes in addition to new services provided under this grant. Each one of Connecticut's Waiver programs (ABI, DMR, PCA, CHCPE, DMHAS) has a quality management component in place. In addition, the nursing facility transition program has a quality management component. Money Follows the Person will add a coordinating effort to

ensure necessary information is shared across departments/divisions focusing on improvements made to the delivery of service to the consumers.

Money Follows the Person will establish a Quality Coordinating Committee that will meet every two months to share information and improve the operation of the quality systems presently in place. This committee will consist of representatives from the administering agencies or units from each of the waivers and the MFP, especially quality assurance staff, representatives of the fiduciary agents and representatives of the transition coordinators (ILCs and AAAs). The Medicaid Director or his designee will chair this committee. Through the sharing of procedures, discussion of provider issues, changes in forms or recommendations for additional site visits, each agency will be able to analyze and work to make changes that are consistent across agencies and populations.

The MFP demonstration will largely reflect QM procedures already in place within respective waiver programs. Demonstration services outside of waivers will have fully coordinated procedures for discovery, remediation and systems improvement. The main function of the QM committee is to assure this level of coordination and communication. Under MFP, UCONN Center on Aging will conduct consumer satisfaction surveys for all people admitted into the MFP program every 6 months. This is the practice currently under the state's transition program and many systemic changes have been made based on the input of the people served.

Waiver programs serve different populations of people across different agencies and have different strengths regarding QM practice. The common threads, however of an effective QM are the same. All programs have:

- Tools and methods to determine appropriate level of need;
- Methods for designing person centered plans that truly offer 'consumer control'.

- Methods for identifying qualified providers
- A process for assuring health and welfare in the home;
- Achievement of standards in Connecticut HCBS established by the Medical Care Administration;
- A method for maintaining fiscal responsibility in programs.

Each Department involved in waiver management will benefit from sharing practices and brainstorming solutions to common problems with systems improvement as the goal. For example, level of needs tools could be shared and Departments may consider modifying tools, incorporating elements as appropriate given the population of people they serve. The closed loop system of discovery, remediation and systems improvement will grow continually stronger. As just discussed, the quality framework will guide the agendas of these committee meetings. The safety and health of participants living in institutions is also a concern. While Connecticut's transition plan is conservative, some nursing facility closures are anticipated. To assure the safety and health of people in the nursing home as the census drops, the DSS may offer payment rate increases during transition to new ownership or options to continue operation with fewer beds per room.

10. An overall description of the State's current quality management system, where the gaps are and what will be developed and implemented in order to ensure the health and safety of consumers who are transitioned and the continuous improvement of HCBS and institutional care: The DSS Medical Care Administration is responsible to assure that the waivers meet the federal requirements and expectations for the quality operation of the HCBS waivers in the State. DSS has had in place a long-standing system of quality assurance to address service planning, service delivery, health and welfare, participant rights and safeguards and financial

accountability for service delivered by providers. The waiver programs are at varying levels of transition between the traditional quality system and the newer quality framework. With the current expansion of multiple waiver programs in the state, DSS is in the process of reassessing all waiver programs with respect to the quality framework.

All waiver programs reflect a values-driven approach to quality designed to assure that individual participants achieve meaningful personal outcomes, have the supports necessary to make choices, informed decisions, experience community opportunities and individual relationships, benefit from system safeguards and experience satisfaction with their services, supports and desired lifestyle.

Gaps to be addressed in MFP

Lack of a coordinated strategy: Connecticut is currently reassessing all of its waivers with respect to the Quality Framework. Connecticut lacks a coordinated strategy. The Quality Coordinating Committee will be established as detailed in question 7 to address this gap.

Lack of capacity within the Department: Connecticut recognizes that with the implementation of MFP, additional staff will be necessary to address implementation of the quality framework. A full-time social worker will be hired to address this gap. The staff person will assist not only within the demonstration but also with the overall coordination of quality management system.

11. A brief description of barriers that prevent the flexible use of Medicaid funds so that money follows the person and a summary of strategies the state will employ under the demonstration to eliminate those barriers An analysis of how the State will use or enhance existing IT systems to address identification of MFP participants including: (a) Demographic information identifying Medicaid and MFP participation eligibility prior to transition; (b)

Financial information to be reported for services eligible for enhanced FMAP according to the MFP demonstration

Connecticut's Medicaid budget within the DSS is a pooled budget as previously discussed. Flexibility exists within the present funding mechanisms to support MFP. Funding is appropriated to a single Medicaid line based on estimates of demand for HCBS. Due to Connecticut's pooled budget, there is no waiting list for the PCA, the ABI or the CHCPE waiver. While there are caps on the capacity of each waiver, Connecticut's past practice reflects what could be called a 'no waiting list' policy. Caps are adjusted based on demand for services. There is a waiting list for DMR services. DMR waivers are not included in the DSS pooled budget. DMR has a monitored plan in place for reducing the waiting list within appropriations.

12. IT System Enhancement

Connecticut has an established database developed under the Nursing Home Transition Grant to collect 171 variables including information from initial intake and assessment to the quality of services. The plan is to develop a web based data collection system within the pre-implementation phase of MFP expanding the existing data collection forms and database.

Connecticut presently has 5 years of data regarding transitions and plans to continue longitudinal assessments of consumer satisfaction with HCBS.

Medicaid utilization data is manually mined to perform cost benefit analysis. Connecticut plans to automate the reporting required under MFP adding additional fields to the MMIS to track individual utilization specific to services. \$400,000 was budgeted for systems development relative to MFP reporting.

Part 3: Preliminary Operational Plan and Budget

Organizational Structure

The attached organizational structure details the placement of the Money Follows the Person Rebalancing Grant within the Department of Social Services. Dawn Lambert will serve as full time Project Director under the Connect to Work Center of the Bureau of Rehabilitation Services. The Connect to Work Center is unique in that it administers a variety of systems change grants, including all of Connecticut's Real Choice Systems Change Grants. The largest award to date is \$5.1 million dollars for the implementation of the Medicaid Infrastructure Grant. The anticipated award for Money Follows the Person will coordinate strategically with the Medicaid Infrastructure Grant to support needed capacity for infrastructure development.

Project Management Staff

The management structure of the MFP Demonstration includes a full-time project director, as well as co-principle investigators. Resumes for each of these individuals are included in Appendix 3. To align the Department's systems change efforts, there will also be management support provided through the Connect to Work Center.

Project Director. Ms. Lambert was the past director of the Nursing Facility Transition Grant awarded by CMS in 2001 and currently oversees its administration. MFP creates a true partnership between the Medicaid Unit (Medical Care Administration) and the DSS programs.

Principle Investigators. Ms Lambert will report to Co-Principle Investigators. Mr. David Parrella, PhD, Director of the Medical Care Administration, will provide oversight in partnership with Ms Brenda Moore, Director of the Bureau of Rehabilitation Services.

Management Support: Ms Amy Porter, ScD will also contribute to the project as director of the Connect to Work Center.

Project Staff. Five additional full time staff will be added to the MFP Demonstration, including the following full-time employees (Job Descriptions are available in Appendix 4):

- A **Health Program Associate** will be hired to provide technical assistance in the field to the 20 contractors providing transition coordination. Past experience in Connecticut has demonstrated a need for this critical function. Field staff need support and benefit from opportunities to problem solve in-group environments. The Health Program Associate will provide this needed function.
- A **Utilization Review Nurse** will have responsibilities for linking preadmission screening with the potential for long-term stay in a nursing facility. This will diversify the manner in which Connecticut's system identifies persons for transition.
- A **Social Worker** hired will have the responsibility for Quality Management in the demonstration and between the other HCBS waivers in the state.
- A **Principal Health Care Analyst** will be hired to assist with the new waiver, the state plan amendments and amendments to exiting waivers.
- A **Fiscal Officer** will manage the MFP budgets and contracts.

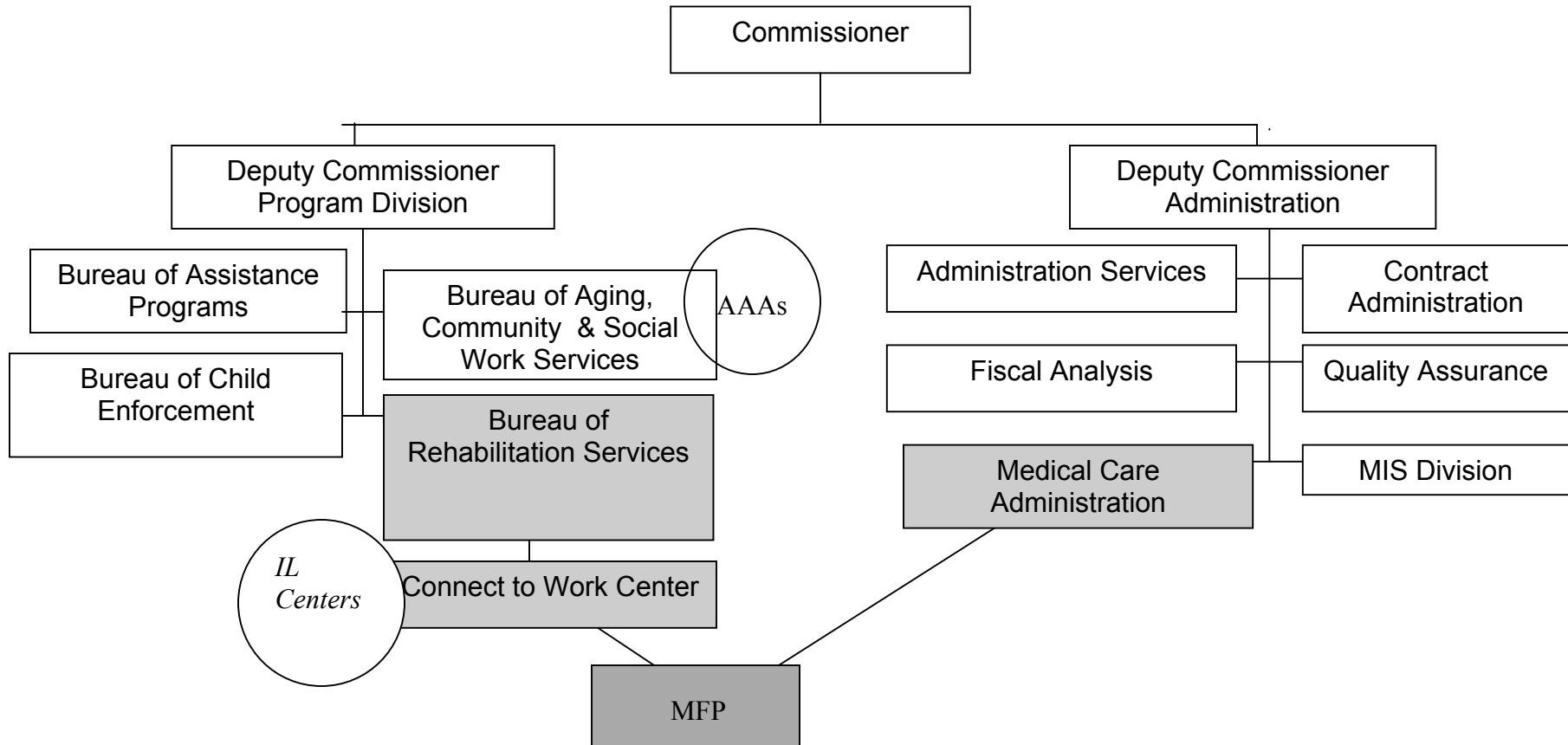
Contract Staff

Transition Coordinators. Connecticut will contract with the five ILCs and the five AAAs for the transition coordination. In total there will be 20 full-time transition coordinators.

Coordinators will provide all coordination and case management functions, including identification of residents, assessment, coordination and follow up for 6 months. Additionally, Connecticut will contract for 5 housing coordinators to facilitate access to housing.

Research. The University of Connecticut Health Center, Center on Aging, will be contracted to provide research to the demonstration. Below is the MFP Organizational Chart.

State of Connecticut
Department of Social Services



Budget

The following assumptions were considered when calculating estimates for the Demonstration years 1 through 5 of the Money Follows the Person Rebalancing Demonstration established under the Section 6071 of the Deficit Reduction Act:

Connecticut will transition over the period of five years 700 residing in qualified institutional settings for at least six months. The transitions will start July 1, 2007 upon approval of the operating protocol.

To estimate the Demonstration Qualified HCBS Program Costs, the per-member, per-month qualified costs were increased by 5% to reflect the inclusion of additional services. The total costs are \$26,153,096.00. A new 24 Hour Live-in Care Option estimated at \$1,684,189.00 was projected to be utilized by 3% of the MFP population and to commence in the 2nd year of the Demonstration. Each new client will require a start-up cost in the first year of transition. The total start-up transition cost for five years will be \$420,000.00.

It was projected that transitioned persons will have various needs to set-up their housing in the community. These include facility modifications, assistive technology as well as food and supplies. These supplemental start-up costs attributed to accessibility modifications were estimated at \$1,000,000.00. Five housing coordinators will be an additional supplemental cost estimated at \$1,256,408.

An ongoing supplemental evaluation will be required to assure the Demonstration's effectiveness at an estimated total cost of \$450,000.00.

It was projected, based on historical trends, that 70% of the transitioned clients will require rental assistance. The rental assistance estimated at \$11,146,199.00 will be funded through other sources.

Administrative costs including DSS Staff, Case Managers, necessary system modifications, travel, supplies, Indirect Costs and Fringe Benefits were estimated at \$9,499,022.

Administrative costs include contracts for transition coordination.

Ongoing costs following the first 12 months after transition from Long Term Care setting total \$33,706,996.00 for the entire demonstration project.

The estimated total demonstration cost for the State and Federal share excluding rental assistance is estimated at \$73,363,298. The total enhanced and non-enhanced Federal share of this Demonstration is estimated to total \$44,374,177.

Part 4: Assurances (5 pages)

Procedures for Informed Consent: Informed consent is at the cornerstone of Connecticut's existing transition program. Transition coordinators work with residents of the nursing facilities on a one-to-one basis to ensure that these individuals fully understand their options for long term care services and supports.

All participants in this demonstration, or an authorized representative, will sign an informed consent form at the time of enrollment. The informed consent form will explain the demonstration project, including the purpose, procedures, risks and benefits of participation. In addition, the informed consent will detail the specific procedures designed to ensure privacy of the participants and confidentiality of the data, the individual's rights and responsibilities, the ways in which they will have choice in selecting their community-based residence, and the supports that they can expect from the project.

Connecticut has been at the forefront of data-driven systems change to support individuals in the community. The current transition program has a data collection and analysis component that is conducted in partnership with the University of Connecticut. As with other Real Choices Systems Change projects, the University will work with DSS under this new demonstration. In this partnership, the rules of the University's Institutional Review Board apply, ensuring that the informed consent procedures meet the strictest guidelines. These guidelines are designed to ensure ethical practice, confidentiality and the avoidance of unnecessary risk.

Public Process for Design, Development and Evaluation: The MFP Demonstration is not a first step in Connecticut's systems change process. Stakeholder input has been solicited, analyzed and incorporated into all of the pieces that will serve as building blocks for this proposal. Some of these steps are described below:

- The Real Choice Systems Change grants of 2001 provided Connecticut with the opportunity to transform stakeholder participation. The Office of Policy and Management contracted with a parent advocate to facilitate the grant applications and process. The products of this transformation have been incorporated into every subsequent systems change application.
- The original Nursing Facility Transition program upon which this demonstration will be built was designed as part of an extraordinary public input process, where a large, diverse group of stakeholders came together in 2001 to design the Real Choice Systems Change strategies.
- At meetings between the state agency group and the stakeholder group, decisions were made by consensus. It was the joint decision of these two groups that future LTC transformation should be governed by a steering committee vested with authority.
- The Nursing Facility Transition program has a successful steering committee guiding its efforts. The gaps for the transition program were documented in a formal report, which the steering committee submitted to DSS as a set of recommendations for the Money Follows the Person Rebalancing Demonstration. DSS staff met with the Steering Committee three times in the development of the MFP proposal.
- The rebalancing goal for this grant comes directly from Connecticut's LTC Plan. This plan was developed by the state's LTC Planning Committee, which includes executive

agency representatives as well as chairpersons and ranking members of several legislative committees. The plan was developed in full consultation with LTC Advisory Committee, which includes consumers, advocates, providers and other key stakeholders.

- The shared vision for Connecticut is stated in the LTC Plan: *“To assure Connecticut residents access to a full range of high-quality long-term care options that maximize autonomy, choice and dignity.” Long Term Care Plan 2004*
- Earlier this year, the state sought funding for a Systems Transformation grant to establish the infrastructure for MFP. During that process, there was a broad-based public input process to identify systems gaps and strengths, and the design of potential infrastructure solutions.
- Other key stakeholders have been involved in the design of the MFP proposal. One concrete example is the Elder Law Section of Connecticut's Bar Association, which has agreed to partner with the DSS MFP project to provide outreach and education to its member attorneys.
- A public meeting was held specifically for the purposes of soliciting input on the MFP proposal. In October, 2006, the major elements of the demonstration were presented at a public hearing at the State's Legislative Office Building. Over 70 people attended this meeting, with 20 providing public testimony to help shape the demonstration.

12,000 Letters! The voice of the consumer in Connecticut's systems change work is the essential first voice in all of the work that we do. While it is important to understand the nature of the change on the various levels of government, it is the needs of the people that drive the change from the beginning to end.

Connecticut has been fortunate to have one particular advocate in this planning process, one person who has reached out to 12,000 people. This individual has been struggling through a personal battle to bring his mother home from a nursing facility, and in so doing, has taken personal responsibility and civic duty to a new level. He made a commitment to get 10,000 letters of support for this proposal. He presented 12,000 letters of support to the Commissioner of DSS at the public meeting in October. He has also been invited to join the project Steering Committee. His voice, and the voices of 12,000 Connecticut citizens, will continue to be heard as the operational protocol is developed and finalized, and the demonstration implemented.

Connecticut's transformation intentionally includes emphasis on person centered planning to ensure a guiding framework focused on the needs of the person as community services are expanded. Transportation, interpreters, personal assistance and other accommodations will be available to assure broad representation of consumers on the steering committee. Once again, Connecticut has a successful track record of including consumers in all aspects of systems change work. From participation on the steering committee, to involvement in work groups, to editing drafts of plans, to receipt of minutes, to leadership positions on the steering committee, Connecticut will assure that the voice of the consumer is central to all systems change work.

Ongoing Steering Committee. The grant-funded Nursing Facilities program established a consumer-controlled Steering Committee in 2001 to guide the development, implementation and evaluation of the program. When the program became state funded in 2004, this Steering Committee remained active as the governing body for the program. The Steering Committee is co-chaired by DMHAS and a consumer who transitioned into the community.

This Steering Committee has been actively involved throughout the development of the MFP Demonstration. It is the state's intention to continue with the existing Steering Committee

framework, with some notable changes. The Medicaid Director will join the Committee, as well as the advocate described above.

The Steering Committee will meet on a monthly basis throughout the demonstration. It is anticipated that a broader group of stakeholders will be involved in workgroups, designed to meet the needs of the Demonstration, as described in Part II of this application. The Operational Protocol will be approved by the Steering Committee prior to submission to CMS.

Maintenance of Effort

As mentioned previously, Connecticut will increase the expenditures on HCBS based on demand. Rebalancing attributed both to nursing facility transitions and increased awareness of HCBS will occur. Additional services to fill gaps currently in the service system today, will be addressed. Connecticut will increase supply of HCBS and anticipates the closure of unneeded nursing home beds.

Reports

The State of Connecticut will submit timely project reports according to CMS specifications. These reports will permit reliable comparisons of MFP projects across states and an effective evaluation of the MFP demonstration